

DEBBY RANSOM, R.N., R.H.I.T – Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, Idaho 83720-036 PHONE: (208) 334-6626 FAX: (208) 364-1888 E-mail: (sb@dhw.idaho.gov

March 23, 2010

James Adamson, Administrator Mountain View Hospital 2325 Coronado Street Idaho Falls, ID 83404-1389

RE: Mountain View Hospital, Provider ID# 130065

Dear Mr. Adamson:

This is to advise you of the findings of the Medicare/Licensure Fire Life Safety Survey, which was concluded at Mountain View Hospital, on March 10, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
- 2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- 5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

James Adamson, Administrator March 23, 2010 Page 2 of 2

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 5, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208) 334-6626.

Sincerely,

MARK GRIMES

Supervisor

Facility Fire Safety and Construction Program

MG/mlw

Enclosure

2/002

Fax Server

PAGE

I DHW

Printed: 03/23/2010 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 130065 03/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN VIEW HOSPITAL 2325 CORONADO STREET IDAHO FALLS, ID 83404 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X6) COMPLETION K 000 INITIAL COMMENTS K 000 The hospital building is Type I fire resistive two (2) story structure with a finished basement. RECEIVED Total square footage within the hospital is 80,000+ (i.e., 11,000+ basement; 44,000+ main level; and 25,000+ second floor). Construction of the hospital was completed in November 2002. APR 05 2010 The building is fully sprinklered; has a complete fire alarm/smoke detection system throughout; a Type I essential electrical system; multipe exits FACILITY STANDARDS from each level; and, smoke barrier partitions on each level. Medical office buildings are attached at each end of the hospital building and are separated from the hospital building by four (4) hour rated wall assembles. The following deficiencies were cited at the above facility during the Fire/Life Safety survey conducted on March 9-10, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR 482.41. The survey was conducted by: Mark Grimes, Supervisor Facility Fire/Life Safety and Construction Program K 021 NFPA 101 LIFE SAFETY CODE STANDARD K 021 Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or

4/7/2010 10:49:22 AM

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the tindings stated above are disclosable 90 days itowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies ere cited, an approved plan of correction is requisite to continued program participation.

FORM CM6-2567(02-99) Previous Versions Obsolete

activation of:

hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon

a) the required manual fire alarm system;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

C94821

If continuation sheet Page 1 of 13

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/23/2010 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING\_ 130065 03/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN VIEW HOSPITAL 2325 CORONADO STREET IDAHO FALLS, ID 83404 (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 021 Continued From page 1 K 021 b) local smoke detectors designed to detect K021 smoke passing through the opening or a required smoke detection system; and PLAN: MVH has developed a "Fire door inspection" Policy. This policy has been approved by the c) the automatic sprinkler system, if installed. board and implements a fire door inspection 19.2.2.2.6, 7.2.1.8.2 program that will track fire door function as well as develop an ongoing fire door log. The policy outlines how the door will be inspected and if a door stop is found it will be removed. RESPONSE: The drop down door stops that were sited have been removed This Standard is not met as evidenced by: EVIDENCE: (1) Refer to TAB 1 SEC 1 Based on observation, the facility failed to ensure that the cross corridor doors to a hazardous area "FIRE DOOR INSPECTION" policy. were provided with a means to self close in an (2) Refer to TAB 1 SEC 2 "SAMPLE LOG SHEET" emergency. The deficient practice would affect (3) Refer to TAB 1 SEC 3: pictures of service staff in the facility. The facility had the capacity for corridor loading dock doors. Note: both drop 45 licensed beds with a census of 22 on the day of the survey. down door stops have been removed. Findings include: During the facility tour on March 9, 2010 between Completion 9:30 and 10:30 am, observation of the rated Date separation doors between the service corridor 3/31/2010 and the loading dock revealed both doors to were propped open by drop down door stops, preventing the doors from self closing in an emergency. This deficiency was noted by facility Maintenance Director and the Surveyor.

19.2.2.2.6

The finding was acknowledged by the Compliance Officer and by the Maintenance Director at the exit interview on March 10, 2010.

Actual NFPA Standard: NFPA 101;

Any door in an exit passageway, stairway

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING\_ 130065 03/10/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HOSPITAL 2325 CORONADO STREET IDAHO FALLS, ID 83404 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG TAG DEFICIENCY) K 021 Continued From page 2 K 021 enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. K 022 K022 K 022 NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily PLAN: Maintenance has purchased and installed visible signs in all cases where the exit or way to illuminated EXIT signs in the following sited areas; reach exit is not readily apparent to the PRE-OP: refer to TAB 2 pictures occupants. 7.10.1.4 POST - OP: refer to TAB 2 pictures SURGICAL CORRIDOR: refer to TAB 2 pictures DIRECTIONAL SIGN: refer to TAB 2 pictures An ongoing maintenance program will be performed by the Maintenance department. They will preform an EXIT illumination check log quarterly. Process and policy was reviewed by the Safety Committee This Standard is not met as evidenced by: Completion Based on observation and interview, the facility Date: failed to provide adequate exit directional 3/26/2010 signage. This deficient practice affected the surgery, pre-op and post-op portions of the main floor, affecting all surgical patients and staff in the surgical suite. The Census was 22 on the date of the survey. Findings include:

During the facility tour on March 9, 2010 between

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B, WING 130065 03/10/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN VIEW HOSPITAL 2325 CORONADO STREET **IDAHO FALLS, ID 83404** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 022 Continued From page 3 K 022 3:00 and 4:30 pm, a lack of exit signage was Refer to TAB 2: observed in the Pre-op, post-op, and surgical corridor, and the need for a directional sign in the short stay hallway. Interview with the maintenance director confirmed that the facility was unaware of the requirements for directional signage within suites. Failure to provide adequate signage would effect timely evacuation in an emergency. The finding was acknowledged by the Compliance Officer and verified by the Maintenance Director at the exit interview on K050 March 10, 2010. Actual NFPA standard: NFPA 101, 2000 Edition 7.10.1.4 Exit Access. PLAN: MVH has updated and approved our Access to exits shall be marked by approved, fire drill policy refer to TAB 3 SEC 1: Policy readily visible signs in all cases where the exit or FIRE DRILL PROCEDURE "1.1 fire drills way to reach the exit is not readily apparent to the will be planned by the facility engineering staff occupants. Sign placement shall be such that no The drill will be part of the engineering PM point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated program and will be set to meet the two per sign and is not in excess of the marked rating for quarter requirement. "Fire drill was performed internally illuminated signs. on March 31, 2010 @ 05:31. Refer to TAB 3 SEC 2 "FIRE DRILL FORM" Safety Committee reviewed drill on March 31, 2010. K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050 Recommendation noted. Fire drill was conducted per "Fire drill procedure" policy. Fire drills are held at unexpected times under varying conditions, at least quarterly on each EVIDENCE: TAB 3 SEC 2 fire drill performed shift. The staff is familiar with procedures and is between 7pm and 7am and reviewed by aware that drills are part of established routine. Responsibility for planning and conducting drills is Safety committee.

Completion

3/31/2010

Date:

19.7.1.2

alarms.

assigned only to competent persons who are

conducted between 9 PM and 6 AM a coded

announcement may be used instead of audible

qualified to exercise leadership. Where drills are

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01

(X3) DATE SURVEY COMPLETED

R WING

		130065		B, WING	·············	03/1	0/2010
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
MOUNTA	AIN VIEW HOSPITA	L		ORONADO FALLS, ID			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENC! Y MUST BE PRECEEDED B LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X6) COMPLETIO DATE
K 050	Continued From pa	age 4		K 050			
	Based on record redetermined that the all required fire drills previous 12 months survey was 22. The Record review on Maisclosed that fire davallable for two of months. Records in three planned day soccurrences (false testing). Maintenanexit interview on Mafire drills forms and for system testing, a formal fire drills. La result in staff not permergency.  The finding was act Compliance Officer	flarch 09, 2010 at 10 drill documentation we four quarters in the lendicated no night shishift drills and six act alarms or sprinkler see Director stated dearch 10, 2010 at 8:45 documentation were and acknowledged a ck of fire drill training properly in knowledged by the	iew it was ured that r the e of the :46 a.m. as not last 12 iff drills, ual eystem uring the 5 a.m. that e filled out a lack of y could a fire		Refer to TAB 3 SEC 2 "Fire drill	Form"	
K 051	A fire alarm system devices or equipme NFPA 72, National effective warning of Activation of the col	FETY CODE STANI with approved compent is installed accord Fire Alarm Code, to fire in any part of th mplete fire alarm sys- itiation, automatic d	oonents, ding to provide e building. stem is by	K 051			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING 01 B. WING 130065

(X3) DATE SURVEY COMPLETED

03/10/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RECH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   REQULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)    K 051   Continued From page 5 patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6    K051   PLAN: Move smoke detector into fire control panel room. It was discovered that the smoke detector had been placed in an adjacent office to the fire control panel room. RESPONSE: Smoke detector was removed from office and placed in the fire control panel room.  This Standard is not met as evidenced by: Based on observation, it was determined that the facility had not insured that the fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70. National Electrical Code and NFPA 72. Census on the date of the survey was 22. The findings include:	MOUNT		2325 CORONADO STREET IDAHO FALLS, ID 83404				
patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6  K051  PLAN: Move smoke detector into fire control panel room. It was discovered that the smoke detector had been placed in an adjacent office to the fire control panel room. RESPONSE: Smoke detector was removed from office and placed in the fire control panel room. RESPONSE: Smoke detector was removed from office and placed in the fire control panel room. EVIDENCE: TAB 4 picture of control room with smoke detector relocated.  Compile C	PREFIX	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION DATE		
detector had been placed in an adjacent office to the fire control panel room.  RESPONSE: Smoke detector was removed from office and placed in the fire control panel room.  RESPONSE: Smoke detector was removed from office and placed in the fire control panel room.  RESPONSE: TAB 4 picture of control panel room.  EVIDENCE: TAB 4 picture of control room with smoke detector relocated.  Complete the survey was 22. The findings include:  Observation on March 09, 2010 at approximately 3:45 p.m., disclosed that facility had not insured protection of the fire alarm control unit. In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. The origin and path of the fire may result in destruction of the control unit before a detector responds.  The finding was acknowledged by the	K 051	patient sleeping areas may be omitted provide that manual pull stations are within 200 feet or nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station.	ed f he of of able.				
Based on observation, it was determined that the facility had not insured that the fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. Census on the date of the survey was 22. The findings include:  Observation on March 09, 2010 at approximately 3:45 p.m., disclosed that facility had not insured protection of the fire alarm control unit. In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. The origin and path of the fire may result in destruction of the control unit before a detector responds.  EVIDENCE: TAB 4 picture of control room with smoke detector relocated.  EVIDENCE: TAB 4 picture of control room with smoke detector relocated.	!			panel room. It was discovered that the smoke detector had been placed in an adjacent office to the fire control panel room.  RESPONSE: Smoke detector was removed			
3:45 p.m., disclosed that facility had not insured protection of the fire alarm control unit. In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location. The origin and path of the fire may result in destruction of the control unit before a detector responds.  The finding was acknowledged by the		Based on observation, it was determined that facility had not insured that the fire alarm syst required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. Census on the	em onal e	EVIDENCE: TAB 4 picture of control room	Completion Date: 3/31/2010		
		3:45 p.m., disclosed that facility had not insur- protection of the fire alarm control unit. In area that are not continuously occupied, automatic smoke detection shall be provided at the local of each fire alarm control unit(s) to provide notification of fire at that location. The origin path of the fire may result in destruction of the	ed as tlon and				
			- 100 - 10				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

130065

A. BUILDING B. WING\_

03/10/2010

NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE

2325 CORONADO STREET

MOONT		2325 CORONADO DAHO FALLS, ID		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 6 Maintenance Director at the exit interview on March 10, 2010	K 051		
K 062	NFPA 101 LIFE SAFETY CODE STANDARI Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFF 25, 9.7.5	:	K062 PLAN: A sprinkler inspection and maintenance policy will be developed with a response to deficiencics note with annual inspections. The Safety Committee will review sprinkler & fire alarm inspections annually. A corrective action plan will be submitted with regards to any deficiencies that are noted by the inspecting	
······································	This Standard is not met as evidenced by: Based on record review and staff interview it determined that the facility had not ensured t the automatic fire sprinkler system was inspe- as often as required. The deficient practice of affect all smoke compartments, residents an staff within the building. The census on the confidence of the survey was 22. The findings include:  Record review on March 09, 2010 at approximately 11:00 a.m. disclosed that annotation indicated the system was overdue for five year maintenance internal valve inspection/obstruction investigated the OS&Y valve supervisory signals were being received at the FACP. Maintenance Director stated during interview on March 10 2010 at 8:45 a.m. that he had not noted the deficiency on the sprinkler system report pro- by the sprinkler contractor.  The finding was acknowledged by the Compliance Officer and verified by the Maintenance Director at the exit interview on March 10, 2010	hat ected would d date  ual ece; ation e not  vided	contractor.  RESPONSE: Fire inspection company was contacted and performed MVH annual sprinkle inspection. Deficiency was noted and a new va was ordered. Fire inspection company "Simple Grinnell" will repair valve and update inspection EVIDENCE: (1) Refer TAB 5 SEC 1 "Fire Sprinkler inspection" policy. (2) Refer TAB 5 SEC 2 "PURCHASE ORDER # 2032259".  (3) Refer TAB 5 SEC 3 "Simplex Grinnell insp (4) Refer TAB 5 SEC 4 "life safety system deficiency notice"	lve x

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01

(X3) DATE SURVEY COMPLETED

130065

B. WING\_\_

03/10/2010

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NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW HOSPITAL		2325 C	ORONADO FALLS, ID				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEEDED B' REGULATORY OR LSC IDENTIFYING INFORM		BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X6) COMPLETION DATE
K 062	Continued From pa	age 7		K 062			
	and Maintenance of Systems, Section 2	ence: for the Inspection, T if Water Based Fire I 2.2, Table 2-1 Summ nspection, Testing ar	Protection ary of				
K 130		LANEOUS CIENCY NOT ON 27	786	K 130	K130 PLAN: Educate staff on proper smomanagement with e-mail and door s RESPONSE: Place temporary signs going to basement that states "This stay Closed at Atl Times". This sign	igns. on door Door Must	
j	NFPA 101, Chapte	ot met as evidenced r 38, Section 3.1.1 all be enclosed or pr 2.5.	Any		replaced with a permanent sign. EVIDENCE: Refer to TAB 6 pietur Care Door at Channing Way".	e "Redi-	Completion
	outpatient urgent ca approximately 4:30	ions during the tour of are clinic on March 0 p.m. it was determine ensure vertical sepa nes.	9, 2010 at ned that				3/31/2010
	The findings include	ed:					
	Channing Way on I revealed a self clos the top of the base with a drop down st observed by the su	he Urgent Care clinion March 09, 2010 obsessing vertical separation ment stair being held tyle door stop. This reveyors and the facil deficiency would allo between floors.	ervation on door at I open was ity				
	Actual Standard						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

130065

A. BUILDING B. WING \_\_\_\_

03/10/2010

NAME OF PROVIDER OR SUPPLIER

MOUNTAIN VIEW HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

2325 CORONADO STREET

IDAHO FALLS, ID 83404

WOOM PAIN TIEM HOOF TIZE		IDAHO FALLS, I		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 130	Continued From page 8	K 130		
	NFPA 101, chapter 38 - 38.3.1.1 Any vertical opening shall be enclosed o protected in accordance with 8.2.5.	r		
K 141	NFPA 101 LIFE SAFETY CODE STAND Non-smoking and no smoking signs in a where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6	reas	K141 PLAN: To educate personal that Oxygen is in use/storage and smoking is prohibited with -in 25 feet from outside door. RESPONSE: Place temporary sign on Oxygen door that will instruct personal that there is	
i	This Standard is not met as evidenced to Based on observation and interview it was determined the facility had not ensured to Smoking Oxygen In Use" signs were dis where oxygen was being stored. Census date of the survey was 22 residents.	as hat "No played	Oxygen in use and stored near by. A permaner sign will be placed on door by April 5, 2010 that will state the distance that must be maintain order to smoke.  EVIDENCE: Refer to TAB 7 picture of outside oxygen storage area with temp sign in place.	ned
	The findings include:  Observation on March 09, 2010 at approact 1:30 p.m. disclosed that medical gas roo not labeled for the use or no smoking. A Smoking Oxygen In Use" sign was not dwhere oxygen and other gases were being stored. Observation was witnessed and surveyors and facility Maintenance Directions.	om was \"No isplayed ng noted by		Completion Date: 4/5/2010
	The finding was acknowledged by the Compliance Officer and verified by the Maintenance Director at the exit interview March 10, 2010	v on		
	Actual NFPA Standard; NFPA 99, 8-6.4.2 Signs. Precautionary signs, readable from a dis	tance of		
ODM OMO	2567/02 00) Davious Versions Obsolets		COAD24 (f continuation sh	ool Pone O of

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 81

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW HOSPITAL    CACH DEFICIENCY MUST BE PRECEEDED BY FULL TAGE   CACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGE   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	010
REGULATORY OR LSC IDENTIFYING INFORMATION)  K 141  Continued From page 9  5 ft (1.5 m), shall be conspicuously displayed wherever supplemental oxygen is in use, and in aisles and walkways leading to that area. They shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.  K 144  NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  K 144  CROSS-REFERENCED TO THE APPROPRIATE  OETICE  CROSS-REFERENCED TO THE APPROPRIATE  CROSS-REFERENCED TO THE APPROPRIATE  OETICE  CROSS-REFERENCED TO THE APPROPRIATE  OETIC  CROSS-REFERENCED TO THE	
5 ft (1.5 m), shall be conspicuously displayed wherever supplemental oxygen is in use, and in aisles and walkways leading to that area. They shall be attached to adjacent doorways or to building walls or be supported by other appropriate means.  K 144  NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  K 144  K 144  PLAN: To generate a process that will ensure the generator log is completed each month. (1)  Designate a person to double check log monthly (2) Have engineering department report quarterly to Safety Committee regarding generator log	(X6) OMPLETION DATE
K 144 NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  PLAN: To generate a process that will ensure the generator log is completed each month. (1)  Designate a person to double check log monthly (2) Have engineering department report quarterly to Safety Committee regarding generator log	
Change generator log policy to reflect action taken and have it approved by Safety Committee and Board of Directors.  RESPONSE: (1) Policy updated and approved	1
(2)Educate all engineering staff on new policy and the importance of performing monthly testing.  EVIDENCE: Refer TAB 8 SEC 1 "Generator monthly testing" policy #9 of "Procedure for testing emergency generators".  (2)Educate all engineering staff on new policy and the importance of performing monthly testing.  EVIDENCE: Refer TAB 8 SEC 1 "Generator monthly testing "policy #9 of "Procedure for testing emergency generators".  (2) Refer TAB 8 SEC 2 "Engineering staff orientation to generator monthly testing policy" (3) Refer TAB 8 SEC 3 sample "Generator Log"	
Record review of the generator log on March 09,	ompleti ate: '2/2010

The finding was acknowledged by the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 (X3) DATE SURVEY COMPLETED

B. WING

•		130065		B. WING		03/10/2010
NAME OF PROVIDER OR SUPPLIER STREET ADD		DRESS, CITY, STATE, ZIP CODE				
MOUNTA	AIN VIEW HOSPITA	L		DRONADO FALLS, ID	STREET 83404	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIC
K 144	Compliance Officer	•	v on	K 144		
	Power Source and (a) Maintenance of generator set or oth associated equipme parts, shall be so m supplying service w practicable and with specified in 3-4.1.1. shall be performed Standard for Emerg Systems NFPA 110 1999 ed 6-4.1 Level 1 and Level 2 appurtenant compo	ion nce and Testing of Ali Transfer Switches. If Alternate Power Souner alternate power sound; including all appuraintained as to be capithin the shortest time of the 10-second inte 8 and 3-4.3.1. Mainte in accordance with Negency and Standby Power Stand	urce. The burce and urtenant pable of erval enance FPA 110, ower		K211 PLAN: (1)develop and implement a policy for the placement of Alcohol rub dispensers. This will instruct er	based hand
K211	Where Alcohol Bas dispensers are insta o The corridor is at o The maximum ind capacity shall be 1 rooms) o The dispensers h from each other o Not more than 10		er es of ing of 4 ft a single	K 211	personal on proper placement of the (2) Education engineering personal RESPONSE: Remove all sited alcolhand dispensers and replace with the distance between them and an ignition Survey the entire hospital for other that are out of compliance with curre EVIDENCE: (1) Refer TAB 9 SEC "Alcohol based hand rub dispenser: (2) Refer TAB 8 SEC 2 Engineering to policy.	on new policy hol based e proper ion source. alcohol dispensers rent policy. 1 new policy installation'.

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03/10/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 130065

(X3) DATE SURVEY COMPLETED

STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW HOSPITAL

MOUNTA	AIN VIEW HOSPITAL	2325 CORONADO STREET IDAHO FALLS, ID 83404				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE		
K 211	Continued From page 11 o Dispensers are not installed over or adjan ignition source. o If the floor is carpeted, the building is ful sprinklered. 19.3.2.7, CFR 403.744, 41460.72, 482.41, 483.70, 483.623, 485.623	lly 18.100,	EVIDENCE CONT: (3) Refer TAB 9 SEC 2 picture of sited Alcohol hand rub dispensers in new locations.	Completion Date: 4/1/2010		
1	This Standard is not met as evidenced by Based on observations and staff interview determined the facility had not ensured compliance with the requirement to maintalcohol based hand rubs (ABHR) a suffici distance from an ignition source. The faci a census of 22 on the date of the survey. The findings include:  Observations on March 09, 2010 between p.m. and 4:30 p.m., disclosed that patient	v, it was ain ent ility had	EVIDENCE CONT: Refer TAB 9 SEC 2			
	38 - 42, and in the hyperbaric suite had had dispensers installed adjacent to or above switches.  This deficiency was corrected immediately maintenance staff.  The finding was acknowledged by the Compliance Officer and verified by the Maintenance Director at the exit interview March 10, 2010	the light y by	pictures of dispenser in HBO chamber moved			
	Actual Standard: Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suite	s of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01

(X3) DATE SURVEY COMPLETED

130065

B. WING

03/10/2010

NAME OF PROVIDER OR SUPPLIER
MOUNTAIN VIEW HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

2325 CORONADO STREET IDAHO FALLS, ID 83404

		IDAHO FALLS, ID	83404	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 12 rooms) o The dispensers have a minimum spacing from each other o Not more than 10 gallons are used in a s smoke compartment outside a storage cab o Dispensers are not installed over or adjac an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418 460.72, 482.41, 483.70, 483.623, 485.623	ingle binet, cent to		

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If continuation sheet 1 of 2

**Bureau of Facility Standards** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 03/10/2010 130065 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2325 CORONADO STREET MOUNTAIN VIEW HOSPITAL IDAHO FALLS, ID 83404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 16.03.14 Initial Comments B 000 B 000 Grimes, Mark The hospital building is Type I fire resistive two (2) story structure with a finished basement. Total square footage within the hospital is RECEIVED 80,000+ (i.e., 11,000+ basement; 44,000+ main level; and 25,000+ second floor). Construction of the hospital was completed in November 2002. The building is fully sprinklered; has a APR 05 2010 complete fire alarm/smoke detection system throughout: a Type I essential electrical system; multipe exits from each level; and, smoke barrier FACILITY STANDARDS partitions on each level. Medical office buildings are attached at each end of the hospital building and are separated from the hospital building by four (4) hour rated wall assemblies. The following deficiencies were cited at the above facility during the Fire/Life Safety survey conducted on March 9-10, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR 482.41 and IDAPA 16.03.14 Rules and Minimum Standards for Hospitals in Idaho. The survey was conducted by: Mark Grimes, Supervisor Facility Fire/Life Safety and Construction Program 16.03.14.510.02 Life Safety Code Requirements BB162 BB162 Life Safety Code Requirements. The hospital shall meet such provisions of the "Life Safety Code", 1985 Edition, of the National Fire Protection Association as are applicable to Health Care Occupancies which is incorporated LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE 10

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PRINTED: 03/23/2010 FORM APPROVED **Bureau of Facility Standards** STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING Λ1 B. WING 130065 03/10/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2325 CORONADO STREET MOUNTAIN VIEW HOSPITAL IDAHO FALLS, ID 83404 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION IĐ (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) BB162 Continued From Page 1 **BB162** by reference. Any hospital in compliance with either the 1967 Edition of the "Life Safety Code" or the 1981 Edition of the "Life Safety Code" prior to the effective date of these rules is considered to be in compliance with this section so long as the hospital continues to remain in compliance with that Edition of the "Life Safety Code." Life Safety Codes are available in the licensing agency of the Department. Remodelings, additions, and/or upgrading of building systems in existing hospitals shall meet the minimum standards set forth in the 1985 Edition of the "Life Safety Code" for new construction. In the event of a conflict between the applicable edition of the Life Safety Code and applicable state or local building, fire, electrical, plumbing, zoning, heating, sanitation or other applicable codes, the most restrictive shall govern. This Rule is not met as evidenced by: Refer to the following deficiencies cited on federal form 2567: K021 Doors Propped Open K022 Exit Signs K050 Fire Drills K051 FACP Smoke Detector Coverage K062 Automatic Sprinkler System Maintenance K130 Vertical Separation at Urgent Care K141 Med Gas No Smoking Signs K144 Generator Testing K211 Alcohol Based Hand Rub Dispensers